IV. EVALUATION

A. Prepayment/Pre-encounter Screens, Audits and Edits

On a quarterly basis, contractors shall evaluate the efficiency of the prepayment/pre-encounter review systems by reviewing those situations and cases where significant losses occurred due to fraudulent practices which could have been prevented by a safeguard in the system of prepayment or internal controls. The findings and proposed remedial action shall be reported to the Contracting Officer in an effort to prevent future losses. The design and application of prepayment/pre-encounter screens shall be accomplished with consideration that claims processing/treatment are not unnecessarily delayed. This review may be a part of the utilization management review in the OPM Part Three, Chapter 3, Section I.

B. Postpayment

The contractor must have written procedures for postpayment utilization review procedures and the reports produced. The contractor shall devise and implement utilization control screens to identify beneficiaries who may be receiving unnecessary services or services at an inappropriate level of care; e.g., repeated hospital admissions, frequent office visits, care provided by multiple providers, etc., or who may not be receiving medically necessary services under managed care. The contractor shall develop a written analysis of services provided by high volume institutional providers. The contractor shall develop a written analysis of services provided by high volume professional and outpatient institutional providers. The procedures shall include criteria for referring cases to professional review. The contractor shall maintain documentation of the action taken on each provider or beneficiary identified with a potential aberrancy by the postpayment utilization reports, including the rationale for the decision. The contractor shall analyze the reports on each provider/beneficiary identified by the postpayment system to determine whether potential fraud or abuse exists. This review may be part of the initial management review in the OPM Part Three, Chapter 3, Section I. and included as a part of the utilization management reports in the OPM Part Three, Chapter 6, Section I.D.1.d.

NOTE:

High Volume beneficiaries are those beneficiaries whose charges exceed $50,000 during a twelve (12) month reporting period. High volume providers are institutional providers whose payments exceeded $750,000; individual providers whose payments exceeded $50,000, Groups/Clinics whose payments exceeded $100,000 (over $25,000 average per professional provider within the group.)

C. Signature Relaxation Program Audit

1. *The contractor's randomly selected, statistically valid postpayment audit requirement shall be used to verify provider compliance with the requirements for beneficiary or other authorized beneficiary representative signature on file. (See the OPM Part Two, Chapter 1, Section IV.F.1.f.)*

2. *If there is some indication that there is potential fraud or abuse, the contractor shall follow the fraud and abuse procedures as specified at Section II. of this chapter.*

D. Provider Signature Authorization-on-File Irregularities

1. *The contractor shall verify facsimile or representative signature authorizations in accordance with the OPM Part Two, Chapter 1, Section IV.D.2.*

2. *If there is some indication that there is potential fraud or abuse, the contractor shall follow the fraud and abuse procedures as specified at Section II. of this chapter.*

E. Problem Provider Cases

1. *On occasion, the efforts to correct a problem provider through the educational efforts of contractor provider relations personnel and contacts by professional peers will have little or no apparent effect. Such cases should be carefully reviewed by the contractor's medical director and/or other peer advisors. If, in the opinion of the contractor's medical director or advisor, the problem poses a threat to the welfare of beneficiaries or a significant problem in utilization of services, the contractor, with concurrence of the contractor's medical director or advisor, should take the following action:*

a. *For contracted providers, the contractor should review its agreement with the provider for compliance and take appropriate action, which may include canceling the agreement.*

b. *For all providers, the contractor shall refer the case to the TMA Program Integrity Branch with the following information:*

(1) *A summary of the issues;*

(2) *A description of how the problem was identified;*

(3) *A description of efforts made by the contractor to resolve the issues and why they were not successful;*

(4) *A description of actions taken, including whether the provider has been placed on one hundred (100) percent review;*

(5) *A copy of all relevant claims, EOBs, and correspondence and other contact records,*

(6) *A provider history for the most recent twenty four (24) month period in either magnetic disk and/or hard copy form, and*

(7) *Any other relevant information (Congressional interest, threat of legal action, appeals currently in progress, etc.).*